Alabama WISEWOMAN Data Collection Form: BASELINE/RISK REDUCTION

SS #: _____/____/_____ Date: ____/____/___ Provider: _____

Name: _____ DOB: ____/____/____ Telephone #: (_____) _____
First Middle Initial Last

Address: _____ Email: _____
City ST ZIP

Race: White ___ Black/AA_____ Asian____ Native Hawaiian or Other Pacific Islander____ American Indian or Alaska Native _____

Ethnicity: Hispanic___ non-Hispanic____ Primary Spoken language in your home: English ____ Spanish____ other: _____

Highest Grade completed: High School Diploma or GED Yes___No___ Circle the highest grade of school completed: 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4

Cholesterol

1. Do you have high cholesterol? Yes____ No____
2. Do you take medication to lower your cholesterol? Yes____ No____ No, could not obtain medication____
3. During the past 7 days (including today), on how many days did you take prescribed medication to lower your cholesterol? Number of days___

Blood Pressure

4. Do you have hypertension **(**high blood pressure)? Yes____ No___
5. Do you take medication to lower your blood pressure? Yes____ No____ No, could not obtain medication____
6. During the past 7 days, on how many days did you take prescribed medication (including diuretics/water pills), to lower your blood pressure? Number of days _____
7. Do you measure your blood pressure at home or using other calibrated sources? Yes____ No, was never told to measure her blood pressure____ No, doesn't know how to measure her blood pressure____ No, doesn't have equipment to measure her blood pressure _____
8. How often do you measure your blood pressure at home or using other calibrated sources?
   Multiple times per day_____ Daily ____ A few times per week ____ Weekly _____ Monthly_____
9. Do you regularly share blood pressure readings with a health care provider for feedback? Yes____ No____

Diabetes

10. Do you have diabetes? (Type 1 or 2?) Yes____ No___
11. Do you take medication to lower your blood sugar (for diabetes)? Yes____ No____ No, could not obtain medication____
12. During the past 7 days, on how many days did you take prescribed medication to lower your blood sugar (for diabetes)? Number of days ____

Cardiac

13. Have you been diagnosed by a healthcare provider as having any of these conditions? Yes _____ No _____

Coronary heart disease or chest pain; heart attack; heart failure; stroke/transient ischemic attack (TIA) ; vascular disease; congenital heart defects

Health Assessment:

1. How much fruit do you eat in an average day? Number of cups____
2. How many vegetables do you eat in an average day? Number of cups____
3. Do you eat two servings or more of fish weekly? Yes____ No____
4. Do you eat 3 ounces or more of whole grains daily? Yes____ No____
5. Do you drink less than 36 ounces (450 calories) of beverages with added sugars weekly? Yes____ No____
6. Are you currently watching or reducing your sodium or salt intake? Yes____ No____
7. How much moderate physical activity do you get in a week? Number of minutes _____ none ___
8. How much vigorous physical activity do you get in a week? Number of minutes _____ none ___
9. Do you smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form)? Current smoker___ Quit (1-12 months ago)____
Quit(more than 12 months ago) ____ Never smoked____
10. About how many hours a day, on average, are you in the same room or vehicle with another person who is smoking? Number of hours ____
Less than 1 hour____ none_____
11. Thinking about your physical health, which includes physical illness and injury, on how many days during the past 30 days was your physical health not good? Number of days_____
12. Thinking about your mental health, which includes stress, depression, or problems with emotions, on how many days during the past 30 days was your mental health not good? Number of days____
13. During the past 30 days, on about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? Number of days_____

Patient: _____ Tracking number: _____ Today's Date: _____

Ht: _____in. Weight: _____lbs. BMI: _____ Waist: ____in. Hip: _____in. **Is Patient Fasting? YES _____ NO _____**

Blood Pressure:

#1 BP reading: _____/_____mm Hg

#2 BP reading: _____/_____mm Hg

AVERAGE BP reading: _____/_____ mm Hg

ALERT/ Disease Level Blood Pressure Documentation:

Was ALERT BP/Disease level evaluation workup completed?

Yes _____ Date: _____

If No: Pt. saw other provider___ Refused____ Lost to follow up _____

Glucose/ A1C Testing:

HgA1C for Diabetes monitoring only by POC HgA1C by POC: _____%

FOR NON-DIABETIC PARTICIPANTS ONLY: Fasting Glucose: _____ mg/dl

***HgA1C for Diabetes Screening** HgA1C by Venipuncture_____%

*Must be submitted to lab for NGSP certified and standardized DCCT assay

Alert/Disease Level Glucose Documentation:

Was Alert/Disease level Glucose workup completed?

Yes _____ Date: _____

If No: Pt. saw other provider ___ Pt. refused____ Pt. lost to follow up ___

Cholesterol and Lipids:

Total Cholesterol: _____mg/dl

HDL Cholesterol: _____ mg/dl

FASTING BLOOD SPECIMENS ONLY:

LDL cholesterol: _____ mg/dl

Triglycerides: _____ mg/dl

Disease Level Cholesterol/lipids Work up Documentation:

Evaluation work up completed? Yes _____ Date: _____

If No: Pt. saw other provider___ Refused____ Lost to follow up _____

ALERT and Disease Levels BP and Lab Values:

***ALERT BP**: **Systolic >180 OR Diastolic >110mm Hg**

Disease Level BP: Systolic ≥ 140 or Diastolic ≥ 90

***ALERT Fasting Glucose**: **≤50 or ≥250 mg/dl**

Disease Level fasting Glucose: ≥ 126 mg/dl

T. Cholesterol= Disease level if fasting, ≥ 240

LDL Cholesterol= Disease level: 160-189

Triglycerides= Disease level: 200-499

***ALERT Action: Requires immediate medical evaluation**

Disease Level Action: Requires medical evaluation within 30 days unless patient is already being treated.

FOR STAFF ONLY: **Risk Reduction Counseling Session:** Start Date: _____ Completion Date: _____

Participant decided as Priority Area?

Nutrition: Yes_____ No ____

Physical activity: Yes_____ No ____

Smoking cessation: Yes ___ No_____

Medication adherence for hypertension: Yes_____ No _____

Readiness to Change Assessment Date: _____

Participant Stage of Change:

- ☐ **Pre-contemplation** (Little or no intention to change)
- ☐ **Preparation** (Ready to plan how she will make a change)
- ☐ **Action** (In the process of trying to make a change)
- ☐ **Maintenance** (Trying to maintain a change)
- ☐ **Refused** (Refused to answer readiness to change questions)

CVD 10-year Risk Calculation: Age: _____ Gender: _____

T. Chol _____HDL: _____ Smoker: _____

SBP: _____CVD Risk: _____%

Was this patient prescribed a **BP** medication **for the first time** today?
Yes ____ No_____

Was this patient prescribed a **Diabete**s medication **for the first time** today? Yes ____ No_____

If this patient is currently taking **BP** or **DIABETES** medication, was an **adjustment** made to this medication today?
Yes ____ No_____

Target Blood Pressure: _____/_____

Reviewed all lab values with patient _____

Reviewed risk factors for CVD, stroke, chronic disease with patient _____ Addressed smoking status _____

Discussed role of diet and **physical activity*** with patient _____ (see question below)

***Does patient have medical clearance to participate in a physical activity program?** Yes___ No___ Date clearance given: _____

Do you wish to participate in a lifestyle intervention program? Yes_____ No_____ Referral Date: _____

For ALERT/Disease Level BP, Glucose or Cholesterol/lipids ONLY:

Medical follow-up Office Visit: _____ Nutritional Counseling Appointment.:_____

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